TATEMEN	ERS FOR MEDICARI	E & MEDI D SERVICES (X1) PROVIDER/SUPPLIER/CLIA	T	\ .	FORM A OMB NO. 0	1938-0:
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	SURVEY
NAME OF		495141	B. WING	······	C	
	PROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP CO		2/2015
	N LIVINGCENTER-ALI		172 CL			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE 6	IX51 COMPLET DATE
F 000	INITIAL COMMENT	rs	F 000			
	survey was conduct 1/22/2015. Three of Significant correction compliance with 42	CFR Part 483, the Federal		Preparation, submission and of this Plan of Correction do an admission of our agreem and conclusions set forth on report. our Plan of Correction and executed as a means to dimprove the quality of care a with all applicable state and regulatory requirements.	nes not constitute ent with the facts the survey on is prepared continuously	
F 155	consisted of 20 curre (Residents # 1 throu closed record review and 24).	05 certified bed facility was e survey. The survey sample ent Resident reviews 19h 18, 22 and 23) and four vs (Residents # 19 through 21 TO REFUSE; FORMULATE VES	F 155			
	The resident has the refuse to participate and to formulate an a specified in paragrap	right to refuse treatment, to in experimental research, advance directive as oh (8) of this section.				
; ; ; ; ; ; ;	specified in subpart I related to maintaining procedures regarding requirements include provide written inform concerning the right to surgical treatment option, formulate an a	g advance directives. These provisions to inform and nation to all adult residents o accept or refuse medical and, at the individual's advance directive. This				
policies to implement advan		cuption of the facility's advance directives and		RECEIVED		
				FEB 0 9 2015		
				VDH/OLC		
RATORY D	IRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNAT	URF			
in p a	potion, formulate an a ncludes a written des policies to implement applicable State law.  IRECTOR'S OR PROVIDER	advance directive. This scription of the facility's advance directives and	cutive	FEB 09 2015 VDH/OLC TITLE Dicector	21:	(X6) DA

Eveni ID: R3RO11

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosabte 90 days following the date of survey whether or not a ptan of correction is provided. For nursing homes, the above findings and plans of correction are disclosabte 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved ptan of correction is requisite to continued

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	RS FOR MEDICARE	& MEDIC ) SERVICES		(	FORM APPROVEI OMB NO. 0938-039
STATEMEN AND PLAN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY CDMPLETED
· · · · · · · · · · · · · · · · · · ·		495141	B. WING	<b>3</b>	C
	PROVIDER OR SUPPLIER  J LIVINGCENTER-ALL	EGHANY		STREET ADDRESS, CITY, STATE, ZIP COD 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	01/22/2015 E
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRE IX (EACH CORRECTIVE ACTION SH	OULD BE COMPLETION
F 155	Continued From pa	ge 1	F 1	155	
	by: Based on review of clinical record review and staff interview, to f 24 residents in the 20), to honor the residecision. The reside	IT is not met as evidenced  a Facility Reported Incident, w, facility document review, the facility staff failed, for one e survey sample (Resident # sident's Advance Directives ent, who had a resuscitation ced dead without the initiation resuscitation (CPR).		Past noncompliance: no plan correction required.	of
	The findings were:				
	year-old male, was a 6/10/11 with diagnos hypertension, cerebriemoral neck fracture anxiety state, hyperlidisease, and osteope Significant Change Nowith an Assessment 2/22/14, and Medicar of 11/10/14, the resident of Cognitive	survey sample, an 88 admitted to the facility on es that included all atherosclerosis, history of e., Alzheimer's Disease, pidemia, peripheral vascular prosis. According to a Minimum Data Set (MDS), Reference Date (ARD) of re 60-Day MDS with an ARD lent was assessed under Patterns) as being severely with a Summary Score of 3			
Г	Review of the Progre esident's closed clini ollowing entries:	ss (Nurses) Notes in the cal record revealed the			
d r: ()	y staff during an adl ound with no signs o Registered Nurse) or	"Resident at 0248 observed (Activities of Daily Living) f life. Notified RN n duty in facility. RN N observed no vital signs.			

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CENIE	RS FOR MEDICARE				(	FO	ED: 02/03/201 RM APPROVE
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	MULTIPLE CONSTRUCTION JILDING			NO. 0938-039 DATE SURVEY COMPLETED
		495141	B. WING	;			С
NAME OF	PROVIDER DR SUPPLIER	······································	-1		STREET ADDRESS, CITY, STATE, ZIP COD		01/22/2015
GOLDE	N LIVINGCENTER-ALL	EGHANY.	}	,	1725 MAIN STREET (REVISED)	E	·
(X4) ID				(	CLIFTON FORGE, VA 24422		
PREFIX TAG	(CACA DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETION DATE
F 155	Continued From page					· · · · · · · · · · · · · · · · · · ·	
	RN also notified MD	and nursing supervisor and	F 1	55			
•	ranniy, ranniy dave	Tacility funeral home					
	preference and the f by RN."	funeral (home) was contacted					
	death this nurse assilife resident presenter pulse this writer pronwriter notified nursing of kin family gave fur funeral home notified According to the Deacause of death for Resident and the presented the presen	"At approx (approximately) of the difference of possible essed resident for signs of ed with no respirations or sounced death at 0248 this graph supervisor, M.D., and next neral home preference l.(sic)"					
! ! !	On 11/24/2014, the fa Reported Incident (VA following, "Resident p by the RN charge nur	acility submitted a Facility A00030682) that noted the ronounced dead at 2:48 am se. Resident noted during					
s	Resident # 20's clinica Resuscitation Orders igned by the attending ollowing:	al record included a " form, dated 6/13/11 and g physician, that noted the					
A ris C re m	ware of the medical c fter fully discussing a sks/benefits and alter PR in a cardiac or res sident or the resident ade the following dec	natives to the initiation of					

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Facility ID: VA0285

If continuation sheet Page 3 of 53

CCIVI	ERS FOR MEDICARE	AND HUMAN SERVICES			(	F(	TED: 02/03/20 DRM APPROVE
O 1 W L CIVIE	NT OF DEFICIENCIES LOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	(X2) MULTIPLE CONSTRUCTION A. BUILDING			NO. 0938-039 DATE SURVEY COMPLETED
NAME OF	PROVINCE	495141	B. WING				С
	PROVIDER OR SUPPLIER N LIVINGCENTER-ALL	EGHANY		1	STREET ADDRESS, CITY, STATE, ZIP COI	01/22/2015 P CODE	
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	א מיווטו	IXS) COMPLETION DATE
F 155	Administrator and the survey team address lack of CPR for Resident	2/15, during a meeting the which included the e Director of Nursing, the sed their concerns over the dent # 20. The	F 19	55			
	QAPI committee reviet 11/21/14 and subseque agreeable with action	the following information of correction.  ewed the self report initiated uent follow-up plan and is taken and monitoring that he date for completion will be					
; }	* Licensed nurses havorocess for checking a	ent the facility has taken the /e been re-educated to the ind implementing advance c "code" process and use of					
ii V C	The current CPR cer icensed nurses has be mmediate courses offe endor for those in nee onfirmed that CPR cen ne time of the investiga	een reviewed with ered by the contracted d of refreshment. It was tified staff were present at					
* D M tra	The Executive Director of Clinical Education and the process	or re-educated the					

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Facility ID: VAD285

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CEIVIE	ERS FUR MEDICARE	AND HIJMAN SERVICES			( ;	PRINTE FOR	D: 02/03/2016 MAPPROVED	
ISTATEMEN	NY OF DEFICIENCIES OF C ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL[	ILTIPL DING	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		495141	B. WING				C	
NAME OF	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE	01	<u>1/22/20</u> 15	
GOLDE	N LIVINGCENTER-ALL	.EGHANY		17	725 MAIN STREET (REVISED)			
(X4) ID			[	C	LIFTON FORGE, VA 24422			
PREFIX TAG	(SACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D DE	IXSI COMPLETION OATE	
F 155	Continued From page	ro 4	-					
	*In-house expiration	s for the prior 6 months were	F1	55				
	* All open charts we Records and Social s codes status were co	re audited by Medical Services to ensure that prrectly documented.						
	<ul> <li>All open charts were documents were filed jackets.</li> </ul>	re audited to ensure that within the correct file						
	* Mock Code Drills in	nitiated on all shifts					}	
	* Hospice administra their code status	tion verified the accuracy of						
; I	* Crashcarts were re- necessary supplies w	assessed to ensure all ere accessible.						
•	oratos in each active	reviewed current code Resident with Resident/RP wishes are being honored.						
F to b w h	Red Ink was placed at one come misfiled or the come misfiled or the cith access to Medical ospice nurses were in the come along with re-e	signature be illegible. Staff Records, including r-serviced on this new						
a	spect of double check eing filed into the corr	ing that documents are						
М	onitoring of compliand	ce will occur as follows:						
Th Re	ne Executive Director esidents that expired i	will run the list of n-house from Point Click						

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Facility ID: VA0285

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	TERS FOR MEDICARE	AND HUMAN SERVICES		(	PRINTED: 02/03/2015 FORM APPROVED
STATEN ANO PI.	IENT OF OEFICIENCIES AN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO	- TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) OATE SURVEY COMPLETED
NAME	OF PROVIOER OR SUPPLIER	495141	B. WING	<del></del>	С
	EN LIVINGCENTER-ALL	EGHANY		STREET AOORESS, CITY, STATE, ZIP COOE 1725 MAIN STREET (REVISED)	01/22/2015
(X4) li PREFI TAG	^ (= .0) 000000000	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL C IOENTIFYING INFORMATION)	IO PREFI) TAG	CROSS-REFERENCEO TO THE APPROI	ADC 25-11/21
F 164 SS=D	the physicians' order statuses were implemented to bot the OPS report for action of the OPS report for	pletion of the monthly his list will be compared to s to ensure that code mented properly. The ED will h the Area VP and QAPI via diditional follow-up.  or/designee will run a list of ing the completion of the eport. The charts affected sure that the documents for he Resident's jacket and per the new process. The s to both the Area VP and port for additional follow-up.  In will continue their end of the greater focus on ensuring bused in the correct Any identified concerns will tely and reported to the follow-up to the QAPI  I PERSONAL TIALITY OF RECORDS ght to personal privacy and her personal and clinical  les accommodations, ten and telephone anal care, visits, and resident groups, but this cility to provide a private	F 164	DEFICIENCY)	NATE ONE
	Except as provided in pa	aragraph (e)(3) of this			

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES		(	PRINTED: 02/03/201 FORM APPROVE
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495141	B. WING		C
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	01/22/2015
GOLDE	N LIVINGCENTER-ALL	EGHANY.		1725 MAIN STREET (REVISED)	
				CLIFTON FORGE, VA 24422	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE COMPLETION
F 164	Continued From page	ne 6			
	section, the residen	t may approve or refuse the	F 16	i4	•
	release of personal individual outside th	and clinical records to any		F164	
	resident is transferre institution; or record  The facility must kee contained in the resit the form or storage release is required b healthcare institution contract; or the resid  This REQUIREMENT by:  Based on medication and staff interview, the	; law; third party payment ent.  This not met as evidenced a pass and pour observation are facility staff failed to		LPN #2 was re-educated on need to close/lock out the computer prevent exposure of personal All Residents have the potential described by this potential described by the Director of the the D	omputer screen unattended to al information.  Intial to be ficient practice.  The re-educated on ctor of Clinical conced to screen when add to prevent ation. A The reve this practice timent Manager's or observation interest or observation
;	maintain confidential on one of 3 units: B w resident information o screen. Findings include:	onfidential electronic medical record (s) units: B wing. Staff left confidential ormation displayed on the computer clude:		will be turned in to the Director additional education as real The Director of Nursing will noted on the Non-clinical rouprovide this trending to QAP months to ensure compliance achieved or for additional rectifications.	trend issues and I monthly for 3
l s r r	conducted 1/21/15 be LPN (licensed practical surveyor approached ight back. I need to com." This surveyor on the medication cart	d pour observation was ginning at 7:45 a.m. with all nurse) # 2 . As this LPN # 2 , she stated "I'll be to (name of resident)'s noted the computer screen was left up displaying a ding personal information		if required.  Date of compliance: 2/11/15	

(i.e. name, date of admission, medical diagnoses,

etc.). Approximately two to three minutes passed; the computer screen did not go to a

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CENT	ERS FOR MEDICARE	AND HUMAN SERVICES  & MEDI D SERVICES		( .	PRINTED: 02/03/2015 FORM APPROVED OMB NO. 0938-0391
STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495141	B. WING	-	· C
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/22/2015
GOLDE	N LIVINGCENTER-ALL	EGHANY		1725 MAIN STREET (REVISED)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	THE COMPLETION
F 164	were walking up and medication cart was resident room, and a beside the cart.  As this surveyor and pass, LPN # 2 left the resident information unattended when ad resident room.  The administrator ar were informed of the	During this time, several staff down the hallway. The parked just outside a a resident was standing  I LPN # 2 continued the med be computer screen up with displayed and left ministering medications in a and DON (director of nursing) above observations during a	F 1	64	
F 224 SS=G	On 1/21/15 at approximation was interviewed regal being left up with rest LPN # 2 stated "Usual screensaver mode at inactivity; I don't know shutting the lid of the so the information wow No further information exit conference.  483.13(c) PROHIBIT MISTREATMENT/NE  The facility must developlicies and procedum	wwhat happened. I've been computer the rest of the day on't be displayed."  I was provided prior to the GLECT/MISAPPROPRIATN elop and implement written es that prohibit, and abuse of residents	F 224	F224  Resident #14 was imm by nursing and a treatm her burn. The PT invoi incident was removed f this facility and investig notifications to APS/Or and DHP. The inciden with facility direct care huddles the following m assistance with future pr	lent obtained for lived in the from practice at gated with nbudsman/VDH t was reviewed staff in daily

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awareness of risks.

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residents was free from negligence during treatment with a therapy device. A physical therapist left Resident #14 unattended during electrical stimulation (e-stim) therapy which was against the facility's clinical practice guidelines for use of the device. During the unsupervised treatment the resident experienced four (4) second degree burns to her left thigh that required over three months of topical treatment in addition to 7 days of oral antibiotic therapy for infection in the wounds. The resident had scarring to her thigh from the burns.

# The findings include:

Resident #14 was admitted to the facility on 3/30/10 with diagnoses that included intellectual disability, depressive disorder, psychosis, dementia, hypothyroidism, hyperlipidemia, seizure disorder, gastroesophageal reflux disease and obstructive sleep apnea. The minimum data set (MDS) dated 1/9/15 assessed Resident #14 as cognitively intact. This MDS assessed Resident #14 had limited range of motion of both lower extremities and required the extensive assistance of two people for bed mobility.

A facility reported incident form dated 1/2/14 documented Resident #14 experienced four second degree burns to her left thigh as a result of unsupervised treatment with an electrical

the FDA to report the incident and insure that all proper channels were followed to protect all residents. No other situations of this type are known to have occurred in this facility.

Facility staff to be re-educated by the Director of Clinical Educations/ designee on or before 2/6/15 as to the requirement to ensure that E-stim treatments are provided under direct supervision. The GEM program Specialist will re-educate the therapy staff on the policies regarding supervision during E-stim treatments on or before 2/6/15. The E-Stim equipment continues to be inspected by Patterson Medical for calibration and safety annually as required. The Aegis GEM Program Specialist will continue to visit at least quarterly and assesses compliance with safety practices in regards to the E-Stim equipment with immediate corrective action and education provided as needed. A report of his findings will be provided to the facility Executive Director.

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CENTERS FOR MEDIC	ALTH AND HIP AN SERVICES ARE & MEDICAID SERVICES		(	PRINTED: 02/03/20 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICAT(ON NUMBER:	(X2) MUL A. BUILOI	TIPLE CONSTRUCTION NG	OMB NO. 0938-039 (X3) OATE SURVEY COMPLETED
	495141	B. WING		C
NAME OF PROVIOER OR SUPP	LIER ,			01/22/2015
T TAME (CACH DEFICE	Y STATEMENT OF OEFICIENCIES	lo	STREET AOORESS. CITY. STATE. ZIP CO 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422 PROVIDER'S PLAN OF CORR	OE ECTION
NEGOLA, OKT	OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AF OEFICIENCY)	
F 224 Continued Fron	n page 9	F 04		
stimulation devidocumented: "( received e-stim management of administered by treatment was deprocedure. Upon four (4) burns we locations where placed. The investion of an estimation of an estim	ce on 12/31/13. The report On 12/31/13 (Resident #14) treatment to her left thigh for pain. This treatment was (physical therapist). The ocumented as being a 25 minute n completion of the treatment, ere noted to the left thigh in the two (2) electrodes had been estigation shows that the Physical stering the treatment had garding maintaining line of rvision of the Resident during the stim treatment. It is determined sets the definition of neglect and ontractor has been removed from cility"	F 22	The Executive Director will Aegis GEM Program Specia reports for trends and submit information at least quarterly QAPI Committee for addition recommendations and to ensure compliance with this plan.  Compliance date: 2/11/15	lists this to the
was in the room was in the room was in the room was in the room was interested and the resident's left thight stated, "(Resident therapist) it was here family member stated accompanied here	The resident #14 was The resident's family member with the resident. The resident's no was with Resident #14 on rviewed at this time about the ent's thigh. The family member sed the physical therapist apply vice electrode pads to the n area. The family member #14) told her (physical urting, that it was too much." er stated the therapist told she could not turn the setting r the device would be off. The ted the therapist then but of the room to walk with her g. The family member stated			

back to the room the therapist did not FORM CMS-2567(02-99) Previous Versions Obsolete

when they were coming back from C wing, "I heard her (Resident #14) hollering." The family member stated when she and the therapist got

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CENTE	RS FOR MEDICARE	AND H AN SERVICES		(	PRINTED: 02/03/20 FORM APPROVI
JOINTON	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION NG	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
	***	495141	B. WING	·· <del>·</del>	С
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	01/22/2015
	N LIVINGCENTER-ALL			1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	3352
(X4) ID PREFIX TAG	(CACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
ir a r v L C ir ti (h h si di el # to di	member stated the tashe still had a few man be applied. The fam therapist removed the resident's thigh the resident's thigh the resident's thigh the resident's think she (the stated, "It (burns) hurfor the burns to heal." If don't think she (the stated that I had been she to stated the serious when she hurt." The family member at this resident's bed sheet a small, slightly oval deals as shaped, linear regular	the e-stim pads even though elling in pain. The family herapist told Resident #14 ore minutes for the device to ily member stated when the e e-stim electrodes from the esident's skin under the burned. The family member stated, rapist) took her (Resident se said it (e-stim therapy) mber stated the burns on the resident's thigh. The stime pulled back the eat made visible the eat. The resident had an ear, dark pink/purplish slightly touter thigh. Below this was ime size dark pink/purplish ly member stated these he burns from the herapy of 12/31/13.  In. Resident #14 was burns to her left thigh from sident #14 stated, "It (therapist) put it on. I told there after applying the sident #14 ther after applying the	F 22		

Resident #14's clinical record was reviewed on

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CENTE	RS FOR MEDICARE	AND HUIAN SERVICES & MEDIC SERVICES		1,	PRINTED: 02/03/2015 FORM APPROVED
STATEMEN	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION OING	OMB NO. 0938-0391 (X3) OATE SURVEY COMPLETEO
NAME OF		495141	B. WING	G	C 04/22/204#
NAME OF	PROVIOER OR SUPPLIER		-l	STREET AODRESS, CITY, STATE, ZIP COOE	01/22/2015
GOLDEN	N LIVINGCENTER-ALL	EGHANY		1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG	PROVIDER'S PLAN OF CORRECTION FIX (EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
	dated 11/26/13 for p week for 12 weeks) to the left thigh area Resident #14's thera documented the resident ments prior to 1 therapy log listed the The log stated, "Elec (Supervised), to one treatments in Decemas lasting from 15 to treatment on 12/31/1 session.  The clinical record in physician progress nodcumented ongoing dressing changes to through 4/22/14. In at the resident was presidays of antibiotic therwounds. Nursing not progress of Resident 12/31/13 at 2:11 p.m. wound to L (left) thigh hree burn wounds to single burn to distal L	th had a physician's order hysical therapy (5 times per that included e-stim therapy for pain management. apy log for December 2013 ident received 16 e-stim 2/31/13. The entry on the etreatment to be supervised. Strical stimulation, or more areas" The aber 2013 were documented 30 minutes each. The 3 was listed as a 20 minute cluding nursing notes, otes and physician orders a topical treatment and the burns from 12/13/13 addition to topical treatments scribed/administered seven apy due to infection in the des documented the following	F2	224	

cm (centimeters) x 0.5 cm... 2.8 cm x 1 cm and... 1.2 cm x 0.9 cm. Distal burn wound measures 1.5 cm x 0.7 cm. Wound beds are pale light green in color with white defined margins..." 1/13/14 - "Negative healing to L thigh burn wound with new order noted for tx (treatment)...Upper grouping of wounds with soft yellow slough tissue and heavy thin yellow drainage with no odor. Surrounding tissue reddened with warmth

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DEPAR	CIMENT OF HEALTH	I AND HU" `N SERVICES			ĺ	PRINTE	D: 02/03/201
CENTE	RS FOR MEDICARE	& MEDIC. JD SERVICES			(	FOR	M APPROVE
STATEMEN	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ULTIPLE CONSTRUCTION DING		(X3) D	O. 0938-039 ATE SURVEY OMPLETED
NAME OF	PROVIDER OR SUPPLIER	495141	B. WINC	S			C 1/22/2015
WAIVIE OF	FROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	1/22/2013
GOLDE	N LIVINGCENTER-ALL				25 MAIN STREET (REVISED) JFTON FORGE, VA 24422		
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t i t	noted"  1/14/14 - "Resident (physician) this more orders regarding wo (milligrams) QID (for daysnew treatment burn wound to L dist sponge of toothette, Apply Silvadene created ay)"  1/15/14 - "Resident of (antibiotic) for wound (antibiotic) for wound infection"  1/18/14 - "Keflex continues infection, left thigh"  1/19/14 - "Continues wound infection"  1/20/14 - "Continues wound infection"  1/20/14 - "Continues wound infection"  1/20/14 - "Resident with a ordered"  2/20/14 - Positive head proximal thigh and Legranulated tissue with margins"  3/6/14 - "Resident with proximal thigh wound and all	was examined by MD ning, resident received new and infection. Keflex 500 mg ur times per day) for seven it orders are to: Gently scrub ital thigh with soap/water using rinse with water and pat dry. am 1% and cover with bam dressing BID (twice per con't (continues) on abx d infection" on ABT therapy for wound on ABT therapy Keflex for on ABT therapy Keflex for essing changed to left thigh aling noted to burn wounds L distal thighAreas are red in red rimmed circular h positive healing to L and L distal thigh wound" ntinues with burns to left int) in place no other skin tinues with burns to left tts continue to burn areas	F	224			
d	a physician progress rocumented, "Pt (pations to L thigh by use	note dated 1/3/14 ent) suffered 4 superficial e of stimulation in PT					

Event ID: R3R011

Facility ID: VA0285

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES  & MEDI( ) SERVICES			(	FC	TED: 02/03/201 DRM APPROVE
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRU	ICTION		NO. 0938-039 DATE SURVEY COMPLETED
······································		495141	B. WING				С
NAME OF	PROVIDER OR SUPPLIER			STREET ADDS	RESS, CITY, STATE, ZIP		01/22/2015
GOLDEI	N LIVINGCENTER-ALL	EGHANY		1725 MAIN S	TREET (REVISED) ORGE, VA 24422	CODE	
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F 224	Continued From page	ne 13				<del></del>	
	(physical therapy)! thickness burns", 1/14/13 stated, "3 ul	L thigh (with) 4 small partial A progress note dated cers high L outer thigh 1 mid	F 2	24			
	The clinical record d sequence of physicia resident's burns on h	ocumented the following an orders for treatment of the ner left thigh.					
	saline solution) and p to distal L thigh with I Hydrogel to all wound pad dressing QD (ea 1/13/14 - "Cleanse gr to proximal L thigh with Cleanse burn wound and pat dry. Apply sawound beds. Cover esilocone (silicone) foaday)" (sic)	to distal L thigh with NSS antyl oint (ointment) to each area with Tegaderm am dressing QD (each					
t r c f r 2 c c d a	imes per day) for 7 days for 7 days for 1/14/14 - Gently scrutchigh with soap/water inse with water and paream 1% and cover voam dressing BID (two bight shift."  1/20/14 - "Cleanse L. pareamser and pat dry.  1/20/14 - Water and pat dry.	b burn wound to L distal using sponge of toothette, at dry. Apply Silvadene with Tegaderm silicone vice per day) every day and eroximal thigh with wound Apply Silvadene cream and pad BID (twice per high with wound cleanser vadene cream and cover ID"					

cleanser and pat dry. LOTA (leave open to air) FORM CMS-2567(02-99) Previous Versions Obsolele

Event ID:R3R011

Facility ID: VA0285

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/03/2015 CENTERS FOR MEDICARE & MEDICARE FORM APPROVED SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IOENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETEO C 495141 B. WING NAME OF PROVIOER OR SUPPLIER 01/22/2015 STREET AOORESS, CITY, STATE, ZIP COOE GOLDEN LIVINGCENTER-ALLEGHANY 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422 SUMMARY STATEMENT OF OFFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH OEFICIENCY MUST BE PRECEOEO BY FULL (X5)PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG COMPLETION TAG CROSS-REFERENCEO TO THE APPROPRIATE DATE OEFICIENCY) F 224 Continued From page 14 F 224 BID...Cleanse L proximal thigh with wound cleanser and pat dry. LOTA (leave open to air) BID..." Treatment and dressing changes to Resident #14's thigh burns were discontinued on 4/22/14. Resident #14's MDS prior to the incident (dated 11/8/13) assessed Resident #14 to require the extensive assistance of two people for bed mobility and transfers. This MDS listed the resident did not ambulate and had limited range of motion of both lower extremities. The resident's care plan during December 2013 listed

mobility and provision of direct care. On 1/22/15 at 9:00 a.m. the director of rehab services was interviewed about Resident #14's burns following e-stim treatment on 12/31/13. The rehab director described the e-stim equipment as a device designed to provide electrical stimulation for the treatment of chronic pain. The rehab director demonstrated the portable device had electrodes connected to lead wires. The rehab director stated the positioning of the electrode pads and settings for the treatment were determined and adjusted by the therapist providing the treatment. The rehab director stated Resident #14 received several weeks of treatment with the e-stim device prior to the incident on 12/31/13. The rehab director stated the e-stim machine used with Resident

the resident was at risk for altered skin integrity due to decreased mobility, obesity and left sided weakness. The care plan documented the resident had "Physical functioning deficit related: MR (mental retardation)/decreased mobility with bilateral weakness..." The care plan listed the resident required two aides at all times for

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AND DIAM 5	I MENT OF HEALTH RS FOR MEDICARE TOF DEFICIENCIES	& MEDIC D SERVICES			PRINTED: 02/03 FORM APPRO	0VF
THE PLAN (	OF CORRECTION	(X1) PROVIDE ASUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVE COMPLETED	ΞΥ
NAME OF S		495141	B. WING		c	
	PROVIDER OR SUPPLIER		<del>'                                    </del>	STREET ADDRESS, CITY, STATE, ZIP CODE	01/22/201	5
GOLDEN	LIVINGCENTER-ALL	EGHANY		1725 MAIN STREET (REVISED)	2	
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F 224	Continued From pag	 ne 15				
	#14 on 12/31/13 was	s inspected and found to be	F 22	4		
1	nee of manufiction.	The rehab director stated the				
'	gevice uso sulfits! C	alibration performed as				
,	redanted with No Calil	bration issues noted. The				
(	of the device require	I the facility's protocol for use d supervision of the resident				
C	during treatment.	The resident				
e ir p R th w fa fro TI w th	e-stim therapy. The anvestigation of the 12 shysical therapist states and the resident #14's thigh are resident's family raing and back. The amily member and thom C wing, they head the administrator states are removed the resign area where the resident and the resign area where the resident is the resident and the resident area where the resident area where the resident is the resident area where the resident area.	m. the administrator was esident #14's burns from administrator stated her 2/31/13 incident revealed the red the e-stim therapy to area and then walked with member from B wing to C administrator stated as the perapist were coming back ard Resident #14 yelling. The led when the e-stim pads ident had 4 burns to the pads had been placed. The				
inv eq for mi	volved had prior train puipment. The admin ruse of the device c ust never be left uns e of sight during trea	ne physical therapist  ning on use of the e-stim  nistrator stated the policy  learly stated the resident				
1111	et the definition of ne	on concluded the incident				

current from an external source to a muscle or FORM CMS-2567(02-99) Previous Versions Obsolete

stimulation involves the introduction of an electric

Event ID: R3RO11

Facility ID: VA0285

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# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/03/2015 FORM APPROVED

	FOR MEDICAR			(	OMB NO. 0938-039	
STATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ER/CLIA (X2) MULTIPLE CONSTRUCTION MBER: A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 224 C	ontinued From pa	age 16	E 2º	24		

nerve. The flow of ions (positive or negative) causes an opposite disruption of the membrane potential which can result in 1) nerve impulses that cause a contraction of muscle, 2) activation of nerve impulses to block transmission of other nerve impulses (as in pain management), and 3) increase circulation which stimulates cellular activity to promote tissue healing and reduce inflammation." This policy listed procedures for use of this device to include, "Prior to first treatment...Make it clear that any stinging, pain or burning sensation under the electrodes is NOT a normal response and that ANY discomfort during treatment must be reported immediately...Establish a clear, reliable method that the patient will use to communicate/signal any treatment intolerance or discomfort..All electrical stimulation treatments MUST be provided in either supervised/line of sight or direct supervised settings. The patient is NEVER to be left unattended or unsupervised...Frequently monitor the skin response during all treatments to confirm acceptable levels...Adjust the treatment setting on the unit in order to achieve the desired response. Verify comfort and tolerance of the patient...Remind the patient to notify treating therapist of any discomfort during the treatment..."

The Lippincott Manual of Nursing Practice 10th Edition on page 1184 defines a second degree burn as a burn assessed with loss of partial skin thickness. This reference describes the characteristics of a superficial second degree burn as, "Pink or red; blisters (vesicles) form; weeping, edematous, and elastic...Superficial layers of skin are destroyed; wound moist and painful...Takes several weeks to heal...Scarring may occur..." (1)

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EvenI ID: R3R011

Facility ID: VA0285

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RS FOR MEDICARE	E & MEDICAID SERVICES			FORM AP	:/U3/201: PROV≓r	
NT OF DEFICIENCIES		<del></del>		OMB NO. 0938-03		
OF CORRECTION	IDENTIFICATION NUMBER:	1				
	495141	B. WING		C		
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N LIVINGCENTER-ALI	FGHANY					
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These findings were administrator and di at 11:45 a.m.	e reviewed with the rector of nursing on 1/22/15					
This was a complain	nt deficiency.					
Health/Lippincott Wil 483.20(d), 483.20(k)	nlladelphia: Wolters Kluwer lliams & Wilkins, 2014. (1) DEVELOP	F 279				
to develop, review ar	nd revise the resident's					
plan for each residen objectives and timeta medical, nursing, and needs that are identifi	t that includes measurable bles to meet a resident's I mental and psychosocial					
to be furnished to attain the phosphest practicable phosphest practicable phosphest well-being 483.25; and any service required under §48 due to the resident's eg483.10, including the	in or maintain the resident's aysical, mental, and as required under vices that would otherwise 33.25 but are not provided exercise of rights under					
y:						
	ERS FOR MEDICARE  TOF DEFICIENCIES OF CORRECTION  PROVIDER OR SUPPLIER  N LIVINGCENTER-ALL  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS  Continued From page  These findings were administrator and di at 11:45 a.m.  This was a complain  (1) Nettina, Sandra M Nursing Practice. Pl Health/Lippincott Wil 483.20(d), 483.20(k) COMPREHENSIVE  A facility must use th to develop, review ar comprehensive plan  The facility must developlan for each residen objectives and timeta medical, nursing, and needs that are identifi assessment.  The care plan must developed that are identifi assessment.  The care plan must developed that are identifi assessment.  The care plan must developed that are identifi assessment.  The care plan must developed that are identifi assessment.  The care plan must developed that are identifi assessment.  The care plan must developed that are identifi assessment.  The care plan must developed that are identifi assessment.  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Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014. 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.25; and any services that would otherwise per required under \$483.25 but are not provided due to the resident's exercise of rights under \$483.10, including the right to refuse treatment under \$483.10(b)(4).	TO DEFICIENCIES TO F DEFICIENCIES OF CORRECTION  (X1) PROVID.  495141  B. WING  PROVIDER OR SUPPLIER  N LIVINGCENTER-ALLEGHANY  N LIVINGCENTER-ALLEGHANY  CI  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  These findings were reviewed with the administrator and director of nursing on 1/22/15 at 11:45 a.m.  This was a complaint deficiency.  (1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. 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This REQUIREMENT is not met as evidenced by:	FORM MEDICARE & MEDICA'' SERVICES  TO DEPIGENMENS OF CORRECTIONS OF CORRECTION  (X1) PROVIDE OR SUPPLIER  1495141  495141  B. WING  TYPE MAIN STREET (REVISED) CLIFTON FORGE, VA 24422  SUMMARY STATEMENT OF DEPICENCES (EACH DEPICENCY WISE DEPICENCY)  SUMMARY STATEMENT OF DEPICENCES  CLIFTON FORGE, VA 24422  THE SECULATORY OR LSC IDENTIFYING INFORMATION)  FREETY  FERTY  FEATH DEPROVIDERS PLAN OF CORRECTION FREETY  FEATH  PROVIDERS PLAN OF CORRECTION FREETY  FEATH  FEATH  FEATH  PROVIDERS PLAN OF CORRECTION FREETY  FEATH  FEAT	

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Facility ID: VA0285

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DEPARTMENT OF HEALTI CENTERS FOR MEDICAR	HAND HUMAN SERVICES		(·	PRINTED: 02/03/2015 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF PROVIDED	495141	B. WING		C .
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/22/2015
GOLDEN LIVINGCENTER-AL	LEGHANY	}	1725 MAIN STREET (REVISED)	
(X4) ID SUMMARY STA	ATEMENT OF DEFICIENCIES		CLIFTON FORGE, VA 24422	İ
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F 279 Continued From pa	ge 18			
review, the facility s	taff failed to develop a	F 27	79 F <b>279</b>	
nightly doses of the	e plan for one of 24 residents e. Resident #7, administered hypnotic medication Ambien, eveloped for insomnia.		A care plan with specific gos interventions for insomnia w developed on 1/22/15 for Re #7.	79 C
The findings include			Current Residents with presc hypnotic medication were re-	dowed
Resident #/ was add	mitted to the facility on 1/7/13		OII 1/3/13 to ensure that care	niana
with a diagnoses that	included helow knoo		will specific goals and interv	Pentions
disease insomnia d	obstructive pulmonary		for insomnia were in place w corrective measures taken as	ith
brain injury anyjety	lepressive disorder, traumatic coronary artery disease,		as a second of the second of t	needed,
congestive heart fail	ure, diabetes, anemia,		The Interdisciplinary team ( I	DT) to
hypertension, episod	IC MOOD disorder and		be re-educated by the Director	rof
psychosis. The mini	Mum data set (MIDS) deter		Chilical Education/designee of	n or
11/14/14 assessed R	(esident #7 as cognitival).		before 2/6/15 as to the require for all residents receiving a hy	ment
mitact and having trot	JDIe talling or staving acloss		to have a care plan specific to	1
7 to 11 out of 14 days	s.		msomnia. The order by order	renewt
Doctdon to			will be printed daily and brows	tht to
1/21/15 The	record was reviewed on		uic clinical start-lin meeting to	}
Order dated 0/4/4 4 for	documented a physician's		ensure that all new orders for hypnotics are communicated to	
3/4/ 14 ID	I IDE DVDDOtic medication		IDT for care planning purpose	o the
be administered as no	trate) 5 mg (milligrams) to		Director of Nursing will reque	et l
bedtime. The resider	ot's medication		validation at the end of day me	etina
administration record	(MAR) for January 2015		that the care plan has in fact be implemented.	en
(##Ough 1/20/15) doc	UMented the resident was		napienied.	
aummistered Ambien	at bedtime on 18 out of 20		The Social Worker will run a re	eno-t
days in January 2015.			or all hypnotics monthly and a	ıdit to
<b></b>			chsure that care plans are curre	nt l
The resident's care pla	an (print date 1/21/15) listed		related to insomnia. Her finding	ac .
the resident was preso	cribed and administered a		will be submitted to QAPI mon	thiy

plans was interviewed about a plan of care for FORM CMS-2567(02-99) Previous Versions Obsolete

hypnotic but included no problems, goals and/or

interventions to address the resident's insomnia.

On 1/21/15 at 1:05 p.m. the registered nurse MDS coordinator (RN #1) responsible for care

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for three months to ensure

Compliance date: 2/11/15

needed.

compliance with the plan or for

additional recommendations if

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CENTEDO ESTADA HEALT	HAND HUMAN SERVICES			PRINTED: 02/03/201
CENTERS FOR MEDICAR	RE & MEDICA SERVICES		(	FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP	01/22/2015
GOLDEN LIVINGCENTER-A			1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	A SHOULD BE CONDITION
This REQUIREMEN by: Based on review of clinical record review, of 24 residents in the 20), to honor the residents. A Licensed Fresponded to the resident.	omnia. RN #1 stated the care ident used a hypnotic but did and/or interventions concernings. RN #1 stated, "We didn't list blem. I don't see that. We nations specifically for insomnia." re reviewed with the director of nursing during a 1/21/15 at 2:00 p.m.	F 281	DEFICIENCY	
The findings were:				
year-old male, was a 6/10/11 with diagnose	survey sample, an 88 and admitted to the facility on es that included al atherosclerosis, history of			

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Facility ID: VA0285

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DEPAR	RTMENT OF HEALTH	AND HUMAN SERVICES				PRIN	TED: 02/03/2015
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	N LIVINGCENTER-ALL			1	725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	-	
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ir	anxiety state, hyperl disease, and osteop Significant Change I with an Assessment 9/22/14, and Medica of 11/10/14, the reside Section C (Cognitive cognitively impaired, out of 15.  Review of the Progressident's closed clin following entries:  11/21/14 - 3:04 a.m. by staff during an adligound with no signs of (Registered Nurse) of assessed resident. FRN also notified MD affamily. Family gave for preference and the furby RN."  11/21/14 - 3:11 a.m. '0245 c-wing nurse no death this nurse assesife resident presented oulse this writer pronounced in family gave functions of kin family gave functions. According to the Death ause of death for Resifarction.	re, Alzheimer's Disease, ipidemia, peripheral vascular corosis. According to a Minimum Data Set (MDS), Reference Date (ARD) of the 60-Day MDS with an ARD dent was assessed under Patterns) as being severely with a Summary Score of 3.  Pess (Nurses) Notes in the ical record revealed the "Resident at 0248 observed (Activities of Daily Living) of life. Notified RN in duty in facility. RN RN observed no vital signs. and nursing supervisor and acility funeral home ineral (home) was contacted acility funeral home ineral (home) was contacted with no respirations or bunced death at 0248 this supervisor, M.D., and next eral home preference (sic)"  The Certificate, the immediate sident # 20 was myocardial	F 2	281			
R	esident # 20's clinica	record included a					}

Eveni ID: R3RO11

Facility ID: VA0285

(f continuation sheet Page 21 of 53

CENTE	RS FOR MEDICARE		<del></del>		PRINTED: 02/03/2015 FORM APPROVED OMB NO. 0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495141	B. WING		С
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD	01/22/2015
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	INTIL DE COMPLETION
F 281	Continued From page "Resuscitation Orde signed by the attend following:	ge 21 rs" form, dated 6/13/11 and ing physician, that noted the	F 28		
	aware of the medica After fully discussing risks/benefits and alt CPR in a cardiac or r resident or the reside made the following di cardiac and/or respira	ernatives to the initiation of respiratory arrest, the ent's representative had ecision: In the event of a atory arrest, initiate CPR."			
	following, "Resident p by the RN charge nur	Acility submitted a Facility A00030682) that noted the pronounced dead at 2:48 am ase. Resident noted during g's follow-up chart review to for full code."			
, ( c f t! v	of Resident # 20) chain (Do Not Resuscitate) to Not Resuscitate) to See the Resident # 20) to be sinding of the DNR for the survey team as LP	ation report of the event IPN (name) checked (name IT and found a yellow DNR IT and determined (name IT and and determined (name IT and by Based on the IT and by the LPN (identified by IPN # 7), resuscitation efforts IT and the Resident # 20 was IT and I			
y n	later discovered dur	rt further noted that it was ing chart review that the ame of Resident # 20) was another resident			

On 1/22/15 at 1:30 p.m., during an overview of the facility's Quality Assurance Program, the Administrator said that LPN # 7 looked at

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If continuation sheet Page 22 of 53

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES  & MEDICA SERVICES		(	PRINTED: 02/03/2015 FORM APPROVED
STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
		495141	B. WING		С
NAME OF	PROVIDER OR SUPPLIER		<b>_</b>	STREET ADDRESS, CITY, STATE, ZIP CODE	01/22/2015
GOLDE	N LIVINGCENTER-ALL			1725 MAIN STREET (REVISED)  CLIFTON FORGE, VA 24422	·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHO	OULD BE COMPLETION
	Incorrectly assumed According to the Adr Residents # 20 and when LPN # 7 looke thought the DNR form The Administrator we during the chart revie of Nursing after their discovered the DNR incorrectly filed in Resident The facility submitted concerning their plant QAPI committee review 11/21/14 and subseque agreeable with action will occur. Compliant 11/26/14  As follow-up to this expolloring action steps to the concerning their plant 11/26/14	rt, saw the DNR form and it was for Resident # 20. ministrator, the signatures of 24 looked to be similar, so d at the signature, she m was for Resident # 20. ent on to say that it was ew conducted by the Director resident's death that it was form for Resident # 24 was sident # 20's clinical record.  If the following information of correction.  We wed the self report initiated uent follow-up plan and is taken and monitoring that ce date for completion will be went the facility has taken the invented implementing advance is code process and use of entification status of all	F 2	.81	

Director of Clinical Education and the Office
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID

immediate courses offered by the contracted vendor for those in need of refreshment. It was confirmed that CPR certified staff were present at

\* The Executive Director re-educated the

the time of the investigated event.

Event ID: R3R011

Facility ID: VA0285

If continuation sheet Page 23 of 53

CENTERS FOR MEDIC STATEMENT OF DEFICIENCIES			(	PRINTED: 02/03/20 FORM APPROV
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPP	LIER		STREET ADDRESS OF THE	01/22/2015
GOLDEN LIVINGCENTER		İ	STREET ADDRESS, CITY, STATE, ZIP COI 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	DE
TOTAL TOTAL CONTRACTOR	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	
F 281 Continued From	1 nage 23			
Manager on the	process for ensuring proper	F 281		
tracking of CPR system.	certification in the Peoplesoft			
*In-house expira reviewed for rep protocols were fo	ations for the prior 6 months were orting to QAPI assurance that ollowed.			
rvecorus and 200	s were audited by Medical cial Services to ensure that recorrectly documented.			
* All open charts	were audited to ensure that filed within the correct file			
* Mock Code Dri	lls initiated on all shifts			
<ul> <li>Hospice adminition</li> <li>their code status</li> </ul>	istration verified the accuracy of			
* Crashcarts were necessary supplie	e re-assessed to ensure all es were accessible.			
argina for 69CU SC	eam reviewed current code tive Resident with Resident/RP ent wishes are being honored.			
Red Ink was place to ensure easy valid become misfiled or with access to Mechospice nurses well process along with	s initiated on 11/24/14 in which sident's name clearly printed in d at the top of each DNR form dation if the form were to the signature be illegible. Staff lical Records, including re in-serviced on this new re-education on the critical necking that documents are			

being filed into the correct resident jacket.

CEN	LERS FOR MEDICARE	AND HUMAN SERVICES				FOR	D: 02/03/2 <b>0</b> 1 M APPROVEI
JOINIEN	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVID: JSUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3) DA	O. 0938-039 TE SURVEY MPLETED
NAME	OF PROVIDER OR SUPPLIER	495141	B. WING	3 <u></u> .		01	C
	EN LIVINGCENTER-ALL	EGHANY	·		STREET ADDRESS. CITY, STATE, ZIP CODE 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422		/22/2015
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F 28	Monitoring of complete Residents that expired Care during the compoperations report. The physicians' order statuses were impleated the OPS report for an another of the CPS report for an another of the CPS report for	itance will occur as follows:  Iter will run the list of ed in-house from Point Click upletion of the monthly his list will be compared to its to ensure that code mented properly. The ED will h the Area VP and QAPI via dditional follow-up.  Iter designee will run a list of ing the completion of the eport. The charts affected sure that the documents for he Resident's jacket and is per the new process. The is to both the Area VP and cort for additional follow-up.  In will continue their end of the greater focus on ensuring oused in the correct Any identified concerns will tely and reported to the	F2	281	DEFICIENCY)		
F 309 SS=G	DNS for trending and committee. 483.25 PROVIDE CAI HIGHEST WELL BEIN	RE/SERVICES FOR	F 309	9	F 309		
	or maintain the highes mental, and psychosog	ceive and the facility must care and services to attain t practicable physical, cial well-being, in amprehensive assessment			Resident #20 was deceased prisurvey. The physician for Resident reviewed the process of oxycood 1/22/15 and scheduled the medit physician for Resident #12 notified of the blood sugars gre 400, and missed medications aron 1/22/15.	ent #7 one on dication. was	

Event ID: R3R011

Facility ID: VA0285

If continuation sheet Page 25 of 53

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/03/2015

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				TIPLE CONSTRUCTION PING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
NAME OF PE	ROVIDER OR SUPPLIER	495141	B. WING		C
	TO AIDEN ON BUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/22/2015
GOLDEN	LIVINGCENTER-ALL	EGHANY	ĺ	1725 MAIN STREET (REVISED)	
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F 309 (	Continued From page	70.25		32 Michory	

Jununued From page 25

This REQUIREMENT is not met as evidenced

Based on review of a Facility Reported Incident, clinical record review, staff interview, and review of facility documents, the facility staff failed, for three of 24 residents in the survey sample (Residents # 7, 12 and 20), to follow physician's orders for cardiopulmonary resuscitation, pain medication administration, blood sugar monitoring, weight monitoring, and medication administration.

- 1. The facility staff failed to provide Resident # 20 with physician ordered cardiopulmonary resuscitation when the resident suffered a cardiac event.
- 2. Facility staff failed to follow a physician's order to assess Resident #7's pain using a numeric scale prior to administering the pain medication oxycodone.
- 3. Facility staff failed to follow physician orders for reporting blood sugars greater than 400, obtaining weights and administering medications to Resident #12.

The findings include:

1. The facility staff failed to provide Resident # 20 with physician ordered cardiopulmonary resuscitation when the resident suffered a cardiac event.

Resident # 20 in the survey sample, an 88 year-old male, was admitted to the facility on 6/10/11 with diagnoses that included

F 309

All open charts were audited to ensure that appropriate advance directive documents were in place by medical records and social services on 11/26/14. All Residents with PRN pain medication and sliding scale insulin are at risk of this potential deficient practice. Weight orders to be audited on or before 2/3/15 for compliance with immediate corrective action if any concerns identified.

A new process was Initiated on 11/24/14 in which a label with the Resident's name clearly printed in Red Ink was placed at the top of each DNR form to ensure easy validation if the form were to become misfiled or the signature be illegible. Staff with access to Medical Records, including hospice nurses were in-serviced on this new process along with re-education on the critical aspect of double checking that documents are being filed into the correct resident jacket. Staff were trained on this new process prior to the survey.

All Residents receiving PRN pain medication had the supplemental documentation Icon turned on within the electronic medication administration system on 1/31/15 to prevent administration of the medication without a documented pain assessment. Restorative Aides will now attend the weekly clinical meeting to ensure they have communication as to discussed order changes for weights. Weight orders will be printed and verified during this meeting.

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CENTERS FOR MEDICAL	TH AND HUMAN SERVICES RE & MEDIC# SERVICES		T.	PRINTED: 02/03/2015 FORM APPROVED
STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDE. SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
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anxiety state, hyper disease, and oster Significant Change with an Assessme 9/22/14, and Medit of 11/10/14, the respection C (Cognitively impaire out of 15.  Review of the Progresident's closed of following entries:  11/21/14 - 3:04 a.m. by staff during an a round with no signs	ebral atherosclerosis, history of cure, Alzheimer's Disease, erlipidemia, peripheral vascular opporosis. According to a employed Minimum Data Set (MDS), not Reference Date (ARD) of care 60-Day MDS with an ARD sident was assessed under we Patterns) as being severely d, with a Summary Score of 3 press (Nurses) Notes in the linical record revealed the inical record revealed the inical record revealed the of lines. Motified RN of life. Notified RN	F 30	rine intedical Director modifies scale insulin orders to better individuals insulin coverage of notifications to only occur for readings outside of order coverage of notifications to only occur for readings outside of order coverage of notifications and insuling the medication will report and the medication and audit tool daily for review a action during their daily stated that the second of the medication of the monthly o	match each orders, with r blood sugar verage limits. un nurses ministration and corrective artup meeting. ewed a second eting . on all of these rector of on or before  gnee will run ing the
assessed resident. RN also notified ME family. Family gave preference and the by RN."  11/21/14 - 3:11 a.m. 0245 c-wing nurse resident presente pulse this writer prorwriter notified nursing of kin family gave fur funeral home notified.	on duty in facility. RN RN observed no vital signs. and nursing supervisor and facility funeral home funeral (home) was contacted  "At approx (approximately) totified this writer of possible tessed resident for signs of the with no respirations or founced death at 0248 this g supervisor, M.D., and next fineral home preference d.(sic)"		report. The charts affected to checked to ensure that the difference for that Resident are in the Rigacket and have been labeled new process. The ED will report for additional follow-un Nursing Administration will contain their end of month chart and greater focus on ensuring that documents are housed in the Resident's file jacket.  They will also review weight contained the pain Scale completion. Any id concerns will be corrected in and reported to the DNS for the follow-up to the QAPI commit	will be flocuments desident's des

infarction.

cause of death for Resident # 20 was myocardial

follow-up to the QAPI committee.

Completion date: 2/11/15

TOTEINENT OF DEFICIENCI		& MEDICALD SERVICES  (X1) PROVID JSUPPLIER/CLIA				OMR	RM APPRO NO. 0938-0
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F 309 Continued Fr	om nac	ne 27				·	
Resident # 20	)'s clinic	cal record industrial	F 30	09			
i vesuscitatio	n ()rder	rs" form dotad out out .					
signed by the following:	attendi	ing physician, that noted the					
"The resident	or the r	resident's decision maker is					*
awale of the t	neucai	condition of the resident. and considering the					
novomenents	and alte	ernatives to the letter of					
Or IV iii a Caru	iac or m	ASDITATORY OFFICE ALL					
i coldelli di (Me	reside	nt's representative had ecision: In the event of a					
our dide and/or	respira	itory arrest, initiate CPR."					
<del></del>	uenom	Resident # 20's stay, dated g physician noted, "As per s remained a do CPR code					
following, "Resi	dent pr ge nurs Vursina	cility submitted a Facility 00030682) that noted the onounced dead at 2:48 am e. Resident noted during 's follow-up chart review to or full code."					
of Resident # 20 (Do Not Resusc of Resident # 20 finding of the DN the survey team	ing. LF ) chart itate) fo ) to be IR form as LPN I and th	on report of the event PN (name) checked (name and found a yellow DNR orm and determined (name a DNR." Based on the by the LPN (identified by 1 # 7), resuscitation efforts are Resident # 20 was ed.					
···iatei uiscuvere	เด ดมาก	further noted that it was g chart review that the ne of Resident # 20) was					

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES  & MEDIC/ SERVICES		(	PRINTED: 02/03/2015 FORM APPROVED
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F 309	Continued From pag not his, but belonged (Resident # 24)."	ge 28 d to another resident	F 30	09	
. !	Administrator said the Resident # 20's char incorrectly assumed According to the Administrator when LPN # 7 looked thought the DNR form The Administrator we during the chart reviet of Nursing after the rediscovered the DNR incorrectly filed in Resident # 2. Facility staff failed to assess Resident #	Assurance Program, the le LPN # 7 looked at t, saw the DNR form and it was for Resident # 20. Ininistrator, the signatures of 24 looked to be similar, so d at the signature, she m was for Resident # 20. In was for Resident # 20. In was for Resident # 20. In was for Resident # 24 was sident # 20's clinical record. It to follow a physician's order 7's pain using a numeric tering the pain medication			
e c b c h p	amputation, chronic of amputation, chronic of disease, insomnia, de orain injury, anxiety, congestive heart failurally pertension, episodicosychosis. The minim	bstructive pulmonary pressive disorder, traumatic oronary artery disease, e. diabetes, anemia			
oi be	/21/15. The record de rder dated 9/4/14 stat	ecord was reviewed on ocumented a physician's ing, "Assess level of pain dent by using numeric pain			

scale: 0-10. 0 = No pain; 10 = Worst Pain..."

Event IO: R3RO11

Facility IO: VA0285

If continuation sheet Page 29 of 53

## DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/03/2015 CENTERS FOR MEDICARE & MEDICARE FORM APPROVED D SERVICES STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495141 B. WING NAME OF PROVIDER OR SUPPLIER 01/22/2015 STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER-ALLEGHANY 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLETION PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 309 Continued From page 29 F 309 The record documented a physician's order for the opioid analgesic oxycodone 10 mg (milligrams) to be administered every 6 hours as needed for pain. The resident's medication administration record (MAR) from 1/1/15 through 1/20/15 was reviewed. The MAR documented the resident was administered a total of 64 doses of oxycodone during this time period. Nursing notes and medication administration notes documented a numeric pain rating for only 17 of the 64 doses of oxycodone administered to Resident #7 from 1/1/5 through 1/20/15 leaving 47 doses of oxycodone administered without a numeric rating. On 1/21/15 at 12:50 p.m. the licensed practical nurse (LPN #2) that routinely administered medications to Resident #7 was interviewed about rating the resident's pain. LPN #2 stated she did not always get a pain rating from the resident prior to administration of the oxycodone. LPN #2 stated Resident #7 complained of pain frequently and specifically requested the oxycodone. LPN #2 reviewed the medication administration notes and nursing notes. LPN #2 stated the pain rating should have been documented in the nursing notes. LPN #2 stated she did not see a pain rating documented for most of the oxycodone doses administered in January (2015).

management of moderate to severe pain. This FORM CMS-2567(02-99) Previous Versions Obsolete

These findings were reviewed with the administrator and director of nursing during a review meeting on 1/21/15 at 2:00 p.m.

The Drug Information Handbook for Nursing 13th Edition on pages 912 through 914 describes oxycodone and an opioid analgesic used for the

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Facility ID: VA0285

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CENT	ERS FOR MEDICARE	AND HUMAN SERVICES  & MEDI D SERVICES			ĺ	FO	ED: 02/03/20 RM APPROVI
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F 309	minaga i ram pa		F 30	)9			
	have a heightened repatient harm when undocuments nursing effectiveness of pair and/or psychological  (1) Turkoski, Beatric Elizabeth A. Tomsik. for Nursing. Hudson 3. Facility staff failed for reporting blood subtaining weights and to Resident #12.	s (ISMP) includes this its list of drug classes which its list of drug classes which its of causing significant itsed in error." This reference actions to include "Monitor for reliefMay cause physical dependence" (1)  Be B., Brenda R. Lance and Drug Information Handbook in Ohio: Lexi-Comp, 2011.  Ito follow physician orders agars greater than 400, it administering medications					
	UZI IZIZU 13 With diagi	mitted to the facility on noses including, but not Schizophrenia, Diabetes, oma and Insomnia.					
	a quarterly assessme	e date) of 12/05/2014. sessed as moderately ive skills with a total					
i	Several physician orde	al record was reviewed. ers were reviewed and ere not followed by facility.					

08/21/2014 stated, "...Blood glucose via fingerstick, notify MD (physician) if results less than 60 or greater than 400..." Subsequent

	DEFAR	MENT OF HEALTH	AND HUMAN SERVICES				PRINTER	D: 02/03/20
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		Continued From pag		F 30	09			
		11/2014 12/2014 or	ns of 9/2014, 10/2014, and 01/2015 revealed the					
	1	following blood sugs	ar results greater than 400:					
	,	09/ 11/2014 - 440 <u>;</u> 1(	)/02/2014 - 441· 1n/na/2n44					
	4	405, 10/09/2014 - 4(	)4: 10/17/2014 - 41a·					
	·	10/21/2014 - 450; 11	1/13/2014 - 510: 11/17/2014 -					
	4	+42, 11/21/2014 - 40	)4: 12/02/2014 - 415·					
	4	127 : 01/01/2015 - 441, 12	2/18/2014 - 448; 12/23/2014 - 48; 01/02/2015 - 449.					
	1	No documentation co	ould be located in the clinical					
	r	ecord that the physic	cian had been notified on any			•		
	u	of the above listed da sugars greater than 4	ates of Resident #12's blood					
	Ŧ	he Administrator an	d DON (director of nursing)					
	W	vere notified of the a	DDVe information during a					
	п	neeting with the surv	/ey team on 01/21/2015 at					
	а	pproximately 2:00 p.	.m.					
	0	n the morning of 01	/22/2015 at approximately					
	I:	30 a.m., this survey	Of Was approached by LDN					
	₩	4 (licensed practical	nurse) regarding Resident					
	#	12 S increased blood	sugar levels. LPN #4					
	SI re	aleu, (IName) physi sident's incressed b	ician is aware of this					
	H	gBA1C jevej. He ha	plood sugars and increased as written about them in his					
	pr	ogress notes." This	s surveyor and LPN #4					
	re	viewed the physicial	n order that stated. "Notify					
	IVI:	บ if BS (blood sugar	r) greater than 400 " if he					ļ
	isi	nt notified then the c	order is not being followed					ł
	LF	'N #4 agreed with th	iis statement. I PN #₄					
	Sta	itea, "So, we need to	o individualize blood sugar		•			1

parameters for each resident? Our company's sliding scale says to call MD if BS greater than 400. So, I guess we need to change the prn (as needed) sliding scale parameters to match the others, so we don't have conflicting orders."

The next physician order dated 11/06/2014

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CENT	RS FOR MEDICARE	AND HUMAN SERVICES  & MEDIC SERVICES		Č	PRINTED: 02/03/2015 FORM APPROVED
STATEMEN	NT OF OEFICIENCIES OF CORRECTION	(X1) PROVIÒER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO	TIPLE CONSTRUCTION DING	OMB NO. 0938-0391 (X3) OATE SURVEY COMPLETED
NAME OF		495141	B. WING		C
GOLDE	PROVIOER OR SUPPLIER  N LIVINGCENTER-ALL			STREET AOORESS, CITY, STATE, ZIP CO 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	01/22/2015 DOE
(X4) IO PREFIX TAG	(EACH DEFICIENCY	FEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG		SHOULD BE COMBLETION
·	stated, "Daily weight Documentation in the weights for the follow 11/08/14, 11/09/14, Resident #12's weight 11/11/14.  An order dated 11/26 weights." Weight resident weights were missed 12/15/14, 12/22/14, order was written on "Monthly weight."  The Administrator and above weight findings survey team on 01/21 p.m.  On 01/22/2015 at appronn.  On 01/22/2015 at appronn.  On 01/22/2015 at appronn.  The last physician ord 01/14/2015 and stated insulins and critical meds. due to system in the following survey.	is x (times) 7 (seven) days. e clinical record included wing dates: 11/07/14, 11/10/14, 11/10/14, 11/10/14, 11/10/14, 11/10/14, 11/10/14. ht was not obtained on 6/2014 stated, "Weekly sults in the clinical record g dates: 11/24/14, 12/01/14. ere documented. Weekly the week of 12/08/14, 12/29/14 and 01/05/15. An 01/07/2015 that stated, d DON were notified of the siduring a meeting with the 1/2015 at approximately 2:00 proximately 12:15 p.m., the put the order in. the order to weigh this weights were not obtained."  Iter was written on d, "Building wide given (sic) edications. Hold all other being down."	F 36	09	

what the order for critical meds included. RN #3 FORM CMS-2567(02-99) Previous Versions Obsolete

including the survey team, the DON was asked what medications were considered critical meds. The DON stated, "Cardiac Meds and Insulins." At approximately 2:20 p.m., RN #3 (registered nurse) joined the meeting. RN #3 was asked

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O LYLEMIS	H UE DEFICIENCIES	& MED AID SERVICES  (X1) PRO JER/SUPPLIER/CLIA			OMR M	O. 0938-039
and plan	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SUR COMPLETE	
NAME OF	PROVIDED OD OUT	495141	B. WING_	<del></del> _		С
	PROVIDER OR SUPPLIER N LIVINGCENTER-ALI	EGHANY		STREET ADDRESS, CITY, STATE, ZIP CODE 1725 MAIN STREET (REVISED)	<u> </u>	1/22/2015
(X4) ID	SUMMARY STA	TEMENT		CLIFTON FORGE, VA 24422		
PRÉFIX TAG	(LUCE DELICIENTY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		IX51 COMPLETION DATE
329 4 SS=E U d d	Review of the MAR #12 included docum not receive her Prop (milligrams) po (orall Novolog 6u (six units meals at 1630 (4:30 documentation in the medications were mi attempted to contact documented these mphone, on 01/21/15 at Neither the Administrates e medications had No further information eam prior to the exit of 183.25(I) DRUG REG JNNECESSARY DRUSACH PROPERSON AND CESSARY DRUSACH PROPERSON	Is included meds for a hypertension and insulin."  For 01/14/2015 for Resident entation that this resident did ranolol HCl 20mg  y) at 1700 (5:00 p.m.) or her entation that this resident did ranolol HCl 20mg  y) at 1700 (5:00 p.m.) or her entation that this resident did ranolol HCl 20mg  y) at 1700 (5:00 p.m.) or her entation of clinical record why these seed. This surveyor the nurse that had issed medications via the nurse that had issed medications via the 1:22 p.m., 01/21/15 at 3:00 10:45 a.m. without success. attor or DON could say why don't been given.  I was received by the survey conference on 01/22/2015.  IMEN IS FREE FROM JGS  egimen must be free from an unnecessary drug is any tessive dose (including for excessive durations as	F 329	F329  Non-pharmacological interve for insomnia were discussed Resident #7 on 2/2/15 by the Registered Nurse Assessment	with	
in ad st co Ba	dications for its use; dverse consequences ould be reduced or combinations of the reased on a comprehen	or in the presence of which indicate the dose liscontinued; or any asons above.		Coordinator (RNAC) and refl his plan of care.  Current Residents with prescr hypnotic medication were interviewed for non-pharmaco interventions related to insome 2/2/15 by the RNAC, with care updates made	ected in ibed logical	
wł giv	argerit, the racility Mil	st ensure that residents		updates made.	; plan	

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/03/2015 CENTERS FOR MEDICARE & MEDI@ FORM APPROVED ) SERVICES STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495141 B. WING NAME OF PROVIDER OR SUPPLIER 01/22/2015 STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER-ALLEGHANY 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX IX5) COMPLETION TAG (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 329 Continued From page 34 F 329 as diagnosed and documented in the clinical Licensed Nurses to be re-educated record; and residents who use antipsychotic by the Director of Clinical drugs receive gradual dose reductions, and Education/designee on or before behavioral interventions, unless clinically 2/6/15 as to the requirement for contraindicated, in an effort to discontinue these current residents receiving a drugs. hypnotic to have attempts at nonpharmacological interventions prior to administration of hypnotics. An order for attempts at nonpharmacological intervention was obtained for each resident receiving a prescribed hypnotic and entered 1-This REQUIREMENT is not met as evidenced 2 hours prior to the administration time of the hypnotic into the Based on staff interview and clinical record electronic medication system. review, the facility staff failed to ensure one of 24 residents in the survey sample was free from The Social Worker will run a report unnecessary medications. Resident #7 was of all hypnotics monthly and audit to administered the hypnotic medication Ambien for ensure that care plans are current 18 out of 20 days in January 2015 without any related to preferred nonpharmacological interventions and prior attempts at non-pharmacological review the medical records to ensure interventions to assist the resident to sleep. that attempts are being made to offer such. Her findings will be submitted The findings include: to QAPI monthly for three months to ensure compliance with the plan or Resident #7 was admitted to the facility on 1/7/13 for additional recommendations if with diagnoses that included below knee needed. amputation, chronic obstructive pulmonary disease, insomnia, depressive disorder, traumatic Compliance date: 2/11/15

Resident #7 was admitted to the facility on 1/7/13 with diagnoses that included below knee amputation, chronic obstructive pulmonary disease, insomnia, depressive disorder, traumatic brain injury, anxiety, coronary artery disease, congestive heart failure, diabetes, anemia, hypertension, episodic mood disorder and psychosis. The minimum data set (MDS) dated 11/14/14 assessed Resident #7 as cognitively intact and having trouble falling or staying asleep 7 to 11 out of 14 days.

Resident #7's clinical record was reviewed on 1/21/15. The record documented a physician's order dated 9/4/14 for the hypnotic medication

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CENTERS FOR MEDI	CARE &	ND HUMAN SERVICES MEDIC O SERVICES		(	PRINTED: 02/03/201 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495141	B. WING		С
NAME OF PROVIDER OR SUP	PLIER		- <del>'</del>	STREET ADDRESS, CITY, STATE, ZIP CODE	01/22/2015
GOLDEN LIVINGCENTE				1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	
TREEN (EACH DEF)	JIENCY MU	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	LILD DE CONTRA
be duffillistered bedtime. The administration 1/20/15 docum administered A days.  Nursing notes a notes documer non-pharmacol administration I administration I administered as resident's curre included no progregarding insom  On 1/21/15 at 1: nurse (LPN #2) evening medicar interviewed about most evenings to sleep and reque "He (Resident #1 LPN #2 stated sit non-pharmacolo promote sleep. I frequently got ag	dem tartred as need as need resident's record (I tented the mbien a send med and med and med and medication is ted the send to the care polems, gunia.  2:50 p.m. that rout the Ambie reside the Ambie and the Ambie and the Ambie reside is the Ambie reside it the Ambie	ate) 5 mg (milligrams) to eded for insomnia at some medication MAR) from 1/1/15 through the resident was at bedtime on 18 out of 20 dication administration administration attempts at any the erventions prior to the final content of the fina	F 32	9	

non-pharmacological interventions to promote FORM CMS-2567(02-99) Previous Versions Obsolete

a care plan for Resident #7's insomnia and of any

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DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES		,	PRIN	TED: 02/03/201
<u> </u>	ERS FOR MEDICARE	& MEDI D SERVICES		ĺ	F	ORM APPROVE
AND PLAI	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION		NO. 0938-039 DATE SURVEY COMPLETED
		495141	B. WING			С
NAME O	F PROVIDER OR SUPPLIER		1			01/22/2015
GOLDE	EN LIVINGCENTER-ALL	EGHANY	J	STREET ADDRESS, CITY 1725 MAIN STREET (R		-
			ļ	CLIFTON FORGE, V	EVISED)	
(X4) ID PREFIX TAG	CEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S X (EACH CORRE CROSS-REFEREI	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From pag	78 36				
	sleep. RN #1 stated resident used a hyperand/or interventions problems. RN #1 st	If the care plan listed the notic but did not provide goals concerning his sleep ated, "We didn't list insomnia it see that. We don't have	F 3	29		
	These findings were administrator and dir review meeting on 1/	ector of nursing during a				
	(zolpidem tartrate) as for the short-term tree Warnings listed includanter evaluation of podisturbance. Failure resolve after 7-10 day or medical illness. Hy associated with abnor changes including deaggression, bizarre behallucinations, and de	s a hypnotic medication used atment of insomnia. de, "Should be used only tential causes of sleep of sleep disturbance to smay indicate psychiatric spnotic/sedatives have been mal thinking and behavior creased inhibition, personalization" (1)				
F 371	Elizabeth A. Tomsik,	B., Brenda R. Lance and Drug Information Handbook Ohio: Lexi-Comp, 2011. CURE, ERVE - SANITARY	F 371			
; ;	The facility must - (1) Procure food from considered satisfactory authorities; and (2) Store, prepare, distunder sanitary conditio	/ by Federal, State or local				
4 CMS-2567	(02-99) Previous Versions Ober	lata –				}

FORM

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	& MEDI D SERVICES		Ċ	PRINTED: 02/03/20 15 FORM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	495141	B. WING	·	С
NAME OF PROVIDER OR SUPPLIER		1 1		01/22/2015
GOLDEN LIVINGCENTER-ALL			STREET ADDRESS. CITY, STATE, ZIP CODE 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	
TUELIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	I <b>D</b> PREFIX TAG	PROVIDER'S PLAN OF CORRECT	II D BE ADMINISTRA
F 371 Continued From page	ge 37	F 37	71	
	•		F371	
υy.	T is not met as evidenced		The snack was removed from the wing pharmacy refrigerator on 1/21/15.	he c
manner in one of 3 n	on and staff interview the store food in a sanitary nedication rooms: C wing. gerator contained unlabeled		All pharmacy refrigerators were checked on 1/21/15 for imprope stored snacks with no additional issues identified.	erly
Findings include:			Licensed nurses to be re-educate the Director of Clinical Education/designee on or before	1
practical nurse) # 6. package of food was This surveyor asked I LPN # 6 stated "I didr there! Maybe it belong This surveyor asked I refrigerator was where LPN # 6 stated "No, the in this refrigerator."	ing medication room ucted with LPN (licensed During the inspection, a observed in the refrigerator. LPN # 6 about the food. It even know that was in gs to (name of resident)." LPN # 6 if the medication e resident food was kept. here should not be any food		2/6/15 as to the policy not to sto any snacks in the pharmacy refrigerators. Dining services st be re-educated on or before 2/6/by the Director of Dining Service to the proper distribution and sto of snacks. A check list has been added to the temperature log she each pharmacy refrigerator for documenting that the refrigerator been checked daily to ensure that snacks have been improperly sto.  Refrigerator logs will be collected.	aff to (15) ces as orage act on r has at no
meeting with facility st. 2:15 p.m. A copy of the resident food items wa time. The DON stated	s have a refrigerator for d not be kent in the		monthly by the unit managers and forwarded to the QAPI committee for review to ensure compliance the plan of correction and addition recommendations if needed.  Compliance date: 2/11/15	ee with

exit conference.
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No further information was provided prior to the

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## DEFAR INVENTION HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDIC AID SERVICES PRINTED: 02/03/2015 FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROV.JER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495141 C B. WING NAME OF PROVIDER OR SUPPLIER 01/22/2015 STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER-ALLEGHANY 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 425 483.60(a),(b) PHARMACEUTICAL SVC -SS=D ACCURATE PROCEDURES, RPH F 425 F425 The facility must provide routine and emergency Resident #9 received her prescription of drugs and biologicals to its residents, or obtain Prolixin with the pharmacy delivery on them under an agreement described in the night of 1/14/15. §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State Current medication supplies were checked law permits, but only under the general by nursing administration on 1/26/15 to supervision of a licensed nurse. ensure medications were available with corrective action taken as needed. A facility must provide pharmaceutical services (including procedures that assure the accurate Licensed nurses to be re-educated by the Director of Clinical Education/designee acquiring, receiving, dispensing, and on or before 2/6/15 as to the process to administering of all drugs and biologicals) to meet order/reorder medication from the the needs of each resident. pharmacy and steps to take if medication not received timely. Any identified issues The facility must employ or obtain the services of will be noted on the 24 hours report for a licensed pharmacist who provides consultation the Unit Manager to provide assistance on all aspects of the provision of pharmacy with any identified issues that cannot be services in the facility. resolved by the Charge Nurse with the pharmacy. Unit Managers will conduct weekly cart audits to ensure that processes are being followed and that all medications are available for administration. This REQUIREMENT is not met as evidenced The Unit Managers will report findings of Based on staff interview and clinical record their cart audits to the DNS during the review the facility staff failed to ensure weekly clinical meeting. The DNS will medications were available for administration for trend issues and review with the QAP1 committee monthly time three months to one of 24 residents, Resident #9. ensure compliance with this plan of Resident #9 did not receive her physician ordered correction and for additional recommendations if required.

Resident #9 did not receive her physician ordered Prolixin on 01/14/2015. The medication, prescribed for treatment of Bi-polar disorder, was ordered to be given in the morning and at

bedtime. Neither dose was given as the medication was not in the facility.

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Date of Compliance: 2/11/15

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CLNIL	RS FOR MEDICAR	HAND HUMAN SERVICES RE & MEDIC SERVICES		(	PRINTED: 02/03/201 FORM APPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA	(X2) MULTI	PLE CONSTRUCTION	<u>OMB NO. 0938-039</u>
		IDENTIFICATION NUMBER:	A. BUILDIN	G	(X3) DATE SURVEY COMPLETED
		495141	B. WING		С
NAME OF	PROVIDER OR SUPPLIES	₹		STREET ADDRESS, CITY, STATE, ZIP COD	01/22/2015
GOLDE	N LIVINGCENTER-AL	LEGHANY	-	1725 MAIN STREET (REVISED)	E
(X4) ID	SUMMARYST	ATEMENT OF DEFICIENCIES		CLIFTON FORGE, VA 24422	
PRÉFIX TAG	(EACH DEFICIENC	LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD DE AND INDI
F 425	Continued From pa	age 39	F 425	5	
; ( ( ( ) r	but were not limited palsy, pulmonary hyperted. The most recent M quarterly assessmenterence date) of Cassessed as having of "15", indicating some	DS (minimum data set) was a cent with an ARD (assessment of 1/14/2015. Resident #9 was go a cognitive summary score he was cognitively intact.  Was reviewed on 01/21/2014 simately 9:00 a.m. The et contained an order for (Prolixin) 10 mg to be given in ocedtime. The MAR stration record) was reviewed. The material interest and initials were adicating whether or not the en. The chart codes listed on other "3" were: "3 (agust sign)			
T n n n a to O (d	The nurse's note sector written on 01/14 ead: Fluphenazine of given, did not arrioted was a note datum.) that read: "Medo system being down uring an end of the director of nursing) a	ction was then reviewed. A 4/2015 at 0507 (5:07 a.m.) HCL 10 mg PO (by mouth) ive from pharmacy." Also ed 01/15/2015 0008 "12:08 dications on hold by MD due n."  day meeting with the DON nd the administrator the s discussed. The DON			

STATEMEN	TOF DEFICIENCIES	AND HUMAN SERVICES  & MEDICALD SERVICES			PRINTED: 02/03/20 FORM APPROVE	
AND PLAN (	OF CORRECTION	(X1) PROV:R/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	495141	B. WING	· · · · · · · · · · · · · · · · · · ·	С	
GOLDEN	LIVINGCENTER-ALL			STREET ADDRESS, CITY, STATE, ZIP CODE 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	01/22/2015	
(X4) ID PREFIX TAG		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORDECT	D D = 1/0/	
F 425	Continued From pag	ge 40	F 42			
5 441 4 6 5 5 5 T 1 1 5 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	conference room she (name of Resident #01/13/2015. It usual nave been here on the ason it did not arrivol1/14/2015 so it was either scheduled time he system being down to further information xit conference on 01 83.65 INFECTION CAPREAD, LINENS the facility must establifection Control Prografe, sanitary and conference on co	ly arrives at night and should be night shift. For some we until the night shift of not here for her to receive at eit had nothing to do with wh."  In was obtained prior to the /22/2015. CONTROL, PREVENT  Dish and maintain an ram designed to provide a infortable environment and we longert and transmission.	F 441			
Pr (1) in (2) sh (3)	) Investigates, contro the facility; Decides what proce ould be applied to an	lish an Infection Control t - ls, and prevents infections dures, such as isolation, individual resident; and				
det pre	Preventing Spread of When the Infection (ermines that a resident the spread of interest the resident.	of Infection Control Program ent needs isolation to fection, the facility must				

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OFILE	39 FUR MEDICARE			(	PRINTED: 02/03/201 FORM APPROVE
AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
NAME OF F	000140	495141	B. WING	· · · · · · · · · · · · · · · · · · ·	С
	ROVIDER OR SUPPLIER		<del>'</del> T	STREET ADDRESS, CITY, STATE, ZIP CODE	01/22/2015
(X4) ID	LIVINGCENTER-ALL		j	1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	-
PREFIX TAG	1 DOOL DELICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	JULD BE SELECT
F 441	Continued From pag	 le 41			
(	(2) The facility must communicable disea	prohibit employees with a	F 44	11 F441	
( ( ) (	direct contact will train the facility must in the facility must in the facility must be seen to the fa	of the residents or their food, if the residents or their food, if the resident contact for which their stated by accepted.		LPN #5 is on a leave of abse She will be re-educated and off on dressing changes prior returning to direct care upon return from her loa.	checked
(; P tr	c) Linens 'ersonnel must hand	le, store, process and to prevent the spread of		All Residents with current dr change orders have the poten be affected.  All staff to be re-educated by	tial to
B re fac pr	ased on observation cord review and faci	is not met as evidenced , staff interview, clinical ity document review, the low infection control d care for one of 24		Education/designee on or bef 2/6/15 on proper techniques f washing. Licensed Nurses to educated by the Director of C Education/designee on or bef 2/6/15 regarding proper dress change infection control pract with associated skills check. I Managers will complete a min of 2 dressing change observation.	ore or hand be re- linical ore ing ices Juit
cha her und cor	ange, was observed bare hands and left capped and lying aga	nurse) #4 did not inds during a dressing to turn off the faucet with a tube of "Multidex" ainst a red bag containing in the dressing change.		per week with re-education prif needed and documentation cobservation submitted to the DThe DNS/designee will trend a issues noted from the Unit Ma observations and submit month QAPI times 3 months for revieus additional recommendations if required.	ovided of the oNS.  any nager ally to
not AKA	limited to: Depressi	Ily admitted to the facility gnoses included but were /e disorder, Recent Left ration), hypothyroidism		Compliance date: 2/11/15	

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDI PRINTED: 02/03/2015 **ID SERVICES** FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OMB NO. 0938-0391 AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 495141 B. WING NAME OF PROVIDER OR SUPPLIER 01/22/2015 STREET ADDRESS, CITY, STATE, ZIP CODE GOLDEN LIVINGCENTER-ALLEGHANY 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) CROSS-REFERENCED TO THE APPROPRIATE COMPLETION TAG DATE DEFICIENCY) F 441 Continued From page 42 F 441 The most recent MDS (minimum data set) was significant change assessment with an ARD (assessment reference date) of 12/01/2014. Resident #4 was assessed as having a cognitive summary score of "04", indicating severe impairment in her cognitive status. On 01/22/2015 at approximately 10:00 a.m., a dressing change observation was conducted with LPN #5 who was assisted by RN (registered nurse) #4. LPN #5 stated that Resident #4 had been medicated for pain prior to the procedure. Resident #4 was turned to her left side. LPN #5 gathered her supplies for the dressing change and pulled Resident #4's brief out from under her. After getting the resident into position LPN #5 washed her hands. She was observed to wash her hands for approximately 7 seconds, she dried her hands and placed the soiled paper towel in a red biohazard bag on the resident's bed. She then turned the water off with her bare hand. LPN #5 continued with the dressing change. Resident #4 had two small areas, one on each side of her buttocks, located in the gluteal fold. LPN #5 treated the wound in the left gluteal fold first. The area was cleaned with wound cleanser and wiped with a nonsterile 4X4 gauze. LPN #5 removed her gloves and again washed her hands for approximately 5-7 seconds. She returned to the bedside and removed the cap from a tube of Multidex. She placed the cap on a clean dry towel on the bed. She used a nonsterile q-tip to apply the Multidex. LPN #5 stated, "This stuff is like honey, it will run, you have to move quickly when you use it."After applying the Multidex, LPN

the dirty gloves she had placed in the red
ORM CMS-2567(02-99) Previous Versions Obsolete

#5 removed her nonsterile gloves and again washed her hands for approximately 5 seconds. She returned to the bedside and picked up one of

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DEPAR CENTE	RTMENT OF HEALTH ERS FOR MEDICARE	AND HUMAN SERVICES  & MEDI( D SERVICES		ž.	PRINTE FOR	ED: 02/03/20 RM APPROVE
STATEMEN	NT OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	OMB No.	O. 0938-039 ATE SURVEY OMPLETED
NAME OF	DDOVIOLD OF OVER	495141	B. WING			С
į	PROVIOER OR SUPPLIER N LIVINGCENTER-ALL			STREET AOORESS, CITY, STATE, ZIP ( 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	CODE	1/22/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	J SHOULD BE	IXSI COMPLETION DATE
	sink to wash her har the bedside she real used q-tip in the bag stated, "I put that in tover again." She lef box of nonsterile glowand washed her han used her bare hand then covered the work she then repeated the right gluteal fold. Durboth gluteal folds the observed to be uncaptowel at the foot of the change the red biohal soiled supplies was of the opened end of the	e stated, "I grabbed the wrong all over." She returned to the rids. When she returned to lized that she had placed the with her clean supplies. She the wrong bag, I need to start the bedside and retrieved a ves. She returned to the sink ds. She dried her hands and to turn the water off. She and with a tegaderm pad, he same treatment to the ring the dressing change to tube of Multidex was upped and lying in the white e bed. During the dressing zard bag containing the bserved to be in contact with	F 44	1		
i i t c tt a o tt	was interviewed. LPP she usually washed he procedure. She state ong because you have the Multidex" LPN favas suppose to washoolicy. She stated, "O asked about the lid be during the procedure, hat because you have are using itit is like her of the wound." It was the opened top of the wound.	₹5 was asked how long				

A copy of the facility policy on handwashing during dressing changes was requested.

"Okay."

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DEP/	ARTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 02/00/00
_CEN	TERS FOR MEDICARE				PRINTED: 02/03/2015 FORM APPROVED
STATEM	EN FOF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	LTIPLE CONSTRUCTION DING	OMB NO. 0938-0391 (X3) DATE SURVEY
		495141	B. WING		COMPLETED
NAME (	OF PROVIDER OR SUPPLIER		D. WING	<del></del>	01/22/2015
	EN LIVINGCENTER-ALL	EGHANY  TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	iD	STREET ADDRESS, CITY, STATE, ZIP CODE 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422 PROVIDER'S PLAN OF CORRECTION	
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	PREFI TAG	A (EACH CORRECTIVE ACTION SHOLD	DDE 000000
SS=E	According to the pol Hygiene": "Washing hands with soap and friction to all surface seconds (or longer) running waterdry h towels and then turn paper towel."  During the dressing of did not wash her han any time. She also dwhen turning off the wased the paper towel or her bare hands to the DON (director of administrator were not information during a mapproximately 11:30 at No further information exit conference on 01.483.75(I)(1) RES RECORDS-COMPLETE.  The facility must maintresident in accordance standards and practice accurately documenter systematically organize. The clinical record must information to identify the sident's assessments.	icy titled, "Handwashing/Hand a Hands Vigorously lather of them together creating is for a minimum of 15 under a moderate stream of lands thoroughly with paper off faucets with a clean, dry change observation LPN #5 ids greater than 7 seconds at lid not follow facility policy water. Each time she either she used to dry her hands turn the water off.  Inursing) and the otified of the above meeting on 01/22/2015 at a.m.  It was obtained prior to the 1/.22/2015.  TE/ACCURATE/ACCESSIB  Itain clinical records on each exith accepted professional es that are complete; d; readily accessible; and ed.  It contain sufficient the resident; a record of the set the plan of care and	F 4	F514  Resident #20 was deceato the survey.  A new inventory sheet prepared by the social was deceated to the survey.	was vorker for with The ed paper ckup on IT I the p system d by cal nsure they
	services provided; the i	results of any g conducted by the State;		occurred again on 1/31/1 with auditing the comple inventory sheets.	5 along teness of

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OEPAR CENTE	CIMENT OF HEALTH	AND HUMAN SERVICES		<i>y</i>	PRINTED FORM	): 02/03/2015 1 APPROVED
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILOI	TIPLE CONSTRUCTION	OMB NO (X3) OAT	. 0938-0391 TE SURVEY MPLETEO
·		495141	B. WING			C
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET AODRESS, CITY, STATE, ZIP COOE	01/	/22/2015
	N LIVINGCENTER-ALL			1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422		
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEDEO BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	IIDBE	IX51 COMPLETION DATE
F 514	Continued From page	de 45			· · · · · · · · · · · · · · · · · · ·	
	and progress notes.		F 51	14		
	This REQUIREMEN	T is not met as evidenced		A new process was init 11/24/14 in which a la Resident's name clearly Red Ink was placed at	bel with the printed in	
	Based on review of clinical record review staff interview, and o	a Facility Reported Incident, v, facility document review, ubservations, the facility staff		each DNR form to ensivalidation to minimize misfiling from illegible that time, staff with according to the control of the con	ure easy risk of writing. At	
	records for two of 24 sample (Residents #	mplete and accurate clinical residents in the survey 15 and 20), and failed to		Medical Records, inclu hospice nurses were in this new process along education on the critica	-serviced on with re-	
	nursing units.			double checking that d are being filed into the resident jacket. Staff v educated to maintain a	ocuments correct vill be re-	
	record of Resident #	ellow Do Not Resuscitate other resident in the clinical 20, which prevented the monary resuscitation during		system to the electroni record and the requirer inventory sheets on or 2/6/15 by the Director Education/designee. In	c medical nent to sign before of Clinical	
;	Resident #15 did r inventory of personal	not have a completed possessions.		sheets will be brought appropriate unit manag up the morning post ac review of completenes	by the ger to stand- lmission for s and	
r	accurate and accessi	to maintain a complete, ble electronic, medical units, Unit A and Unit B, on ystem wide outage.		corrective action if req Paper MARs will be p admissions and month maintained for nurse a event of a system wide	rinted on ly and ccess in the	
	The findings include:	<b>3</b>		The Executive Director		
re ir	orm belonging to anot ecord of Resident # 2	low Do Not Resuscitate ther resident in the clinical 0, which prevented the onary resuscitation during		will run a list of new I during the completion monthly operations rej charts affected will be ensure that the docume Resident are in the Res	of the cort. The checked to ents for that	

Resident # 20 in the survey sample, an 88 year-old male, was admitted to the facility on

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CENTE	ERS FOR MEDICARE	AND HUMAN SERVICES			PRINTED: 02/03/2015 FORM APPROVED
LOINICINEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIL	(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
NAME OF		495141	B. WING	·	С
NAME OF	PRO VIDER OR SUPPLIER		<del></del>	STREET ADDRESS, CITY, STATE, ZIP CODE	01/22/2015
GOLDEI (X4) ID	N LIVINGCENTER-ALL			1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	
PREFIX TAG	(CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	DRE COMPLEMENT
i i i i i i v	anxiety state, hyperlidisease, and osteopolicicant Change Mith an Assessment 9/22/14, and Medical of 11/10/14, the residence of 11/10/14, the residence of 11/10/14, the residence of 11/10/14, the residence of 15.  Review of the Progre resident's closed clinifollowing entries:  11/21/14 - 3:04 a.m. by staff during an adliguity of 15.  Review of the Progre resident's closed clinifollowing entries:  11/21/14 - 3:04 a.m. by staff during an adliguity of 15.  Review of the Progre resident's closed clinifollowing entries:  11/21/14 - 3:04 a.m. by staff during an adliguity staff during an adliguity staff during an adliguity of 16.  Review of the Progre resident's closed clinifollowing entries:  11/21/14 - 3:04 a.m. by staff during an adliguity staff during and the furity RN."  1/21/14 - 3:11 a.m. "/245 c-wing nurse notice ath this nurse assessed resident presented ulse this writer pronouriter notified nursing staff and the furity RN."	ses that included ral atherosclerosis, history of e, Alzheimer's Disease, ipidemia, peripheral vascular orosis. According to a Minimum Data Set (MDS), Reference Date (ARD) of re 60-Day MDS with an ARD lent was assessed under Patterns) as being severely with a Summary Score of 3 ass (Nurses) Notes in the real record revealed the lend of the	F 51		rill rit rig eir ny s s s s s s s s s
O,	kin family gave funer neral home notified.(s	fal nome preference			-

infarction.

According to the Death Certificate, the immediate cause of death for Resident # 20 was myocardial

CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES	E & MED! ID SERVICES		f .	FOR	D: 02/03/20 MAPPROVE
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) D	O. 0938-039 ATE SURVEY OMPLETED
NAME OF PROVIDED A	495141	B. WING			С
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	0	1/22/2015
GOLDEN LIVINGCENTER-ALI	LEGHANY	Í	1725 MAIN STREET (REVISED)	DE	
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES		CLIFTON FORGE, VA 24422		
	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	110111 5 5 5	(X5) COMPLETION DATE
F 514 Continued From page	ge 47	F 5°			
Transcitation Orde	ical record included a ers" form, dated 6/13/11 and ling physician, that noted the				
After fully discussing risks/benefits and alt CPR in a cardiac or resident or the reside made the following discourses.	resident's decision maker is I condition of the resident. and considering the ernatives to the initiation of respiratory arrest, the ent's representative had ecision: In the event of a atory arrest, initiate CPR."		·	·	
On 11/24/2014, the fa Reported Incident (VA following, "Resident p by the RN charge pur-	A00030682) that noted the cronounced dead at 2:48 am se. Resident noted during				
of Resident # 20) char (Do Not Resuscitate) f of Resident # 20) to be finding of the DNR form	tion report of the event PN (name) checked (name t and found a yellow DNR form and determined (name a DNR." Based on the m by the LPN (identified by N # 7), resuscitation efforts he Resident # 20 was ed.				
marci discoveren nimi	Me of Posidont # oo				
On 1/22/15 at 1:30 p.m.	. during an overvious of				

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CENTE	RS FOR MEDICAR	T AND HUMAN SERVICES E & MEDIC^'D SERVICES			7	FOR	ED: 02/03/201 RM APPROVE
ISTATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROV. /SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION	(X3) C	IO. 0938-039 PATE SURVEY OMPLETED
		495141	B. WING	i			C ,
NAME OF	PROVIDER OR SUPPLIER			- 5	STREET ADDRESS, CITY, STATE, ZIP CODE	0	1/22/2015
GOLDE	N LIVINGCENTER-AL	LEGHANY	İ		725 MAIN STREET (REVISED)		
			ľ		CLIFTON FORGE, VA 24422		
(X4) ID PREFIX TAG	(CACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPR DEFICIENCY)	II D RE	IX5  COMPLETION DATE
F 514	Continued From pa	nne 48					
	the facility's Quality	Assurance Program, the	F <sub>.</sub> 5	114			
	Administrator said t	hat LPN # 7 looked at					
	Resident # 20's cha	art, saw the DNR form and					
	incorrectly assumed	t it was for Resident # 20					
	Residents # 20 and	ministrator, the signatures of					
	when LPN # 7 looks	24 looked to be similar, so ed at the signature, she					
	mought the DNR for	rm was for Resident # 20					
	i ne Administrator w	ent on to say that it was					
	ouring the chart revi	ew conducted by the Director					
	or mursing after the	resident's death that it was					
	incorrectly filed in R	form for Resident # 24 was esident # 20's clinical record.					
	2. Resident #15 did	not have a completed					
	inventory of persona	possessions.					
	Resident #15 was ac 7/23/14 with diagnos	dmitted to the facility on					
	Schizophrenia, demo	entia with hehaviore			•		
	depression, deaf, ref	flux, and CVA.					
	The most recent MD	S (minimum data set) was a					i
	quarterly with an ass	essment reference date of					i
	1/6/15, Resident #15	Was assessed as hoing					}
	inoderately cognitive	ly intact with a score 9 of 15.					
	Resident #15's medic	cal record was reviewed on					
	1/22/15 and revealed	an admission "inventory of				•	ł
,	personai possessions	S" form without a date or					ł
•	signatures and an up signatures.	dated inventory list without					1
(	On 1/22/15 at 9:00 a.	m. the social worker was					ļ
C	luestioned regarding	the inventory form. The					
S	social worker verbaliz	ed that upon admission all					1
н	tems are to be descri	ptively written on the					ł
11	nventory list and date	d, signed by the admission					-
R	lurse or certified nurs	ing assistant. If family is					ł

		H AND HUMAN SERVICES E & MEDIC ''D SERVICES		·	PRINTED: 02/03/201 FORM APPROVE
STATEMENT	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
	· · · · · · · · · · · · · · · · · · ·	495141	B. WING		C
GOLDEN	PROVIDER OR SUPPLIER  N LIVINGCENTER-ALL	LEGHANY		STREET ADDRESS. CITY, STATE, ZIP CODE 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	01/22/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 514	Continued From pagesuppose to sign also for themselves.	age 49 so, unless the resident can sign	F 51	14	
	The social worker w #15's inventory list a should have been si	was shown both of Resident and verbalized that the forms signed and dated.			-
	brought to the attent and administrator.	5 a.m. the above finding was nation of the director of nursing. The administrator agreed that story list should have been and signature.			
	3. Facility staff failed accurate and access record on two of thre	n was present prior to exit /15. ed to maintain a complete, sible electronic, medical ree units, Unit A and Unit B, on a system wide outage.			•
; (	an order written 01/1 clinical records was r wide given (sic) insul	onducted 01/21/15 - 01/22/15 14/2015, filed in the paper noted that stated, "Building ulins and critical medications. due to system being down."	e e		
) a a A c	(director of nursing) a 01/21/2015 at approx administration was in above order and syst Administrator stated,	, "PCC system wide was was down company wide."			

medications were given during this outage since the facility medication administration system is electronic. The Administrator stated, "(Name) RN #3 (registered nurse) is who actually came in and handled the situation." The DON stated, "I was

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	TMENT OF HEALTH	AND HUMAN SERVICES  & MEDI : D SERVICES		V.*	PRINTED: 02/03/201 FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495141	B. WING_		C
	PROVIDER OR SUPPLIER	EGHANY		STREET ADDRESS, CITY, STATE, ZIP CO 1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422	01/22/2015 ODE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLETION
F 514	Continued From pa		F 51	4	
	p.m. RN #3 stated, actually called first. (information technol how long the outage meantime, (Name) paystem outage and insulin and critical mand came to the facto take orders off the went down around 7 facility around 8:30 the floor giving medical	eeting at approximately 2:20 "(Name) (another nurse) was I was at home on hold with IT ogy) for forever trying to see a was going to last. In the physician was notified of the he gave the order to give only leds. I finally hung up on IT illity to show the nurse's how a hard charts. The system 1:00 o'clock and I got to the 8:45 p.m. Nurses were on s when I arrived. They were ent in the system what meds came back up."			
	conference room wit #4 stated, "These ar were formed after th packets included a "downtime package" documentation" (for living) when kiosk go don't know why they system went down. paper forms we used inserviced on these wopy of the staff inse by the survey team, I	ADL's - activities of daily bes down. She stated, "I didn't use these when the They have all of the old to use. Staff were when they were formed." A rvice sheets was requested but were never received.			
(	On 01/22/2015 at ap	proximately 7:20 a.m., this			

surveyor was approached by the Administrator and was shown the "Disaster Computer" in its location. The Administrator stated, "This computer automatically downloads all medical records every two hours. If the system goes

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		HAND HUMAN SERVICES E & MEDIC^ ' '⊃ SERVICES			FORM	. 02103/2018 I APPROVE[	
		(X1) PROVIDE JUPPLIER/CLIA IOENTIFICATION NUMBER:	ſ	LTIPLE CONSTRUCTION DING	(X3) OAT COM	OMB NO. 0938-039 (X3) OATE SURVEY COMPLETED	
— · · · ·		495141	B. WING	l		C / <b>22/2015</b>	
NAME OF I	PROVIDER OR SUPPLIER			STREET AOORESS, CITY, STATE, Z	ZIP COOE	<u> Leiru</u>	
GOLDEN	N LIVINGCENTER-ALL	LEGHANY		1725 MAIN STREET (REVISED) CLIFTON FORGE, VA 24422			
(X4) IO PREFIX TAG	(EACH OEFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF IX (EACH CORRECTIVE ACT	CORRECTION TION SHOULO BE THE APPROPRIATE	(X5) COMPLETION DATE	
	Continued From page 51 down you can print MAR's/TAR's (medication administration records/treatment administration records) from this computer. However, on the night in question we were not able to print from this computer. I assumed it was a software issue, but have since found out this computer has to be directly connected to the Lexmark printer in order to print. (Name), head of the IT dept., is going to send me a cheat sheet to use in the future." The Administrator then handed me a copy of a disaster drill that had been conducted on December 23, 2014, on how to use the disaster computer. The Administrator then stated, "I just wanted you to know the company does have drills to make sure the system is working properly. Any time this computer goes off I get an alert sent to my phone. I call the building and have someone go turn the computer back on, like during the ten second delay when the generator comes on."  At approximately 11:45 a.m. on 01/22/2015 the survey team met with the Administrator and DON. The Administrator shared the above information		F 5	<u> </u>			
	again. She stated," wouldn't print becaus (name) IT told me th effect on the disaster was, the printer was that is why we were many MAR's/TAR's when to the Administrator was the recovery drill on I stated, "(Name) DON	"I thought the computer use of a software issue, but ne software doesn't have any ex computer. The problem onto configured correctly and					

asked where is the disaster recovery guidelines kept in the facility. The Administrator stated, "With the disaster computer, but I again thought it

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TATE OF INTER	II (16 NEEKNEMALA)	E & MED 11D SERVICES  [X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II 7	IPLE CONSTRUCTION	FORM APPROV OMB NO. 0938-0	
AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495141  NAME OF PROVIDER OR SUPPLIER  GOLDEN LIVINGCENTER-ALLEGHANY		IDENTIFICATION NUMBER:	A. BUILDIN	(X3) DATE SURVEY COMPLETED		
		495141	B. WING		С	
			STREET ADDRESS. CITY, STATE, ZIP COI 1725 MAIN STREET (REVISED)	01/22/2015 CODE		
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	LOUI D. D. D.	
F 514	Continued From pa wouldn't print becau printer issue."	ige 52 use of a software issue, not a	F 514			
	No further informati	on was received by the survey it conference on 01/22/2015.				
			·			
		·				